

MEMO IN OPPOSITION

FOR IMMEDIATE RELEASE: FEBRUARY 28, 2006

Re: S.1987 (Maziarz)/ A.3106 (Sweeney)

An act to amend the insurance law, in relation to imposing certain limits, requirements and prohibitions regarding the seeking of refunds from health care providers.

This proposal, S.1987/A.3106, imposes a 180-day limit on insurers seeking to recoup legitimate overpayment of claims to health care providers. The New York Health Plan Association (HPA) opposes this legislation for the following reasons:

- 1. Efforts to combat fraud are severely handicapped by this legislation.** While the legislation purports to provide plans an opportunity to examine claims beyond 180-days and make recoveries if fraudulent, sponsors establish a standard that is unrealistic, indeed unobtainable, for appropriate examination of abusive billing practices. To detect abusive billing that is being perpetrated through such practices as upcoding, unbundling and duplicate billing requires the detection of a pattern of deceit that can't be proved by a single claim or even several claims over the prescribed timetable. HPA finds this proposal particularly perplexing in light of the recent *New York Times* series that estimated fraud and abuse in our Medicaid program was as high as 30%. While we anticipate a lower rate of fraud and abuse in the commercial market, it is worth noting that nearly 12 cases of suspected fraud are forwarded by plans to the Department of Insurance for additional review every working day.
- 2. Medicare and Medicaid are afforded up to six years to adjust provider claims. Commercial insurers should not be held to a different or more stringent standard.** The state and federal governments review Medicaid and Medicare claims and make adjustments or seek to recoup payments from providers for services billed for up to *three years*. For certain audits they have the authority to review claims payments for up to *six years*. It is inequitable to impose a 180-day limit on private sector payers while government enjoys a three to six year revision period.
- 3. New York's rigorous prompt pay law requires that plans have the ability to scrutinize paid claims and correct payment errors.** New York's stringent prompt pay law requires insurers to pay duly submitted health insurance claims within 45-days of receipt. Failure to meet this rigorous timeline results in fines and interest penalties of 12 percent. Over the past several years, plans have dedicated significant resources to speed claims payment in response to provider concerns about cash flow. In order to maintain plans' statutory obligation to ensure the proper administration of the law, plans appropriately and routinely review paid claims and make necessary

adjustments. One of the results of New York's prompt pay law is greater scrutiny of certain claims *after* payments are made. This legislation would deny plans that right and establish a one-sided process that fosters higher health insurance costs in New York without improving the administration of the claims processing system.

4. **Providers can (and do) negotiate favorable terms related to a plan's recoupment policies. This legislation undermines those negotiations.** Many providers negotiate clauses into their contracts with plans to address claim recoupment time frames. In exchange for more favorable terms, plans can reach agreement on provisions that are helpful to the administration of the plan, such as prompt submission of claims or arbitration of disputes. This trend clearly illustrates that terms satisfactory to all parties can be achieved in the normal give and take of contract negotiations.

5. **MSSNY rejected state roundtable process.** In 2004, the Department of Insurance convened a roundtable consisting of key stakeholders including hospital representatives, the Medical Society of the State of New York (MSSNY), health plans and other associations to discuss myriad issues related to claims payment including look-back provisions. As a result of these ongoing roundtable discussions it appeared consensus was reached on several claims related issues. However as parties neared final agreement, MSSNY abruptly left the negotiating table and has since been unwilling to conclude these negotiations. MSSNY obviously now prefers a one-sided legislative solution as opposed to a collaborative resolution in which all stakeholders concerns are met. The Legislature should reject any effort by a single group to advance a one-sided agenda (such as this proposal) and urge MSSNY back to the negotiating table to complete a balanced solution to these issues.

For all these reasons, the New York Health Plan Association urges lawmakers to **oppose** S.1987/A.3106.

The New York Health Plan Association represents 30 managed care health plans that provide comprehensive health care services to more than 6 million New Yorkers.